Authorization Of Release/Request of Information

Location of protective health information.

Name of Entity: _____

Address _____

_____

City: _____ **State:** ____ **Zip:** _____

Date of Service _____

SS# _____ **ID #** _____

Name _____

Address _____

_____

Ph _____ **Birthdate** _____

Sex _____ **Race** _____ **Marital Status** _ ____

I hereby authorize the release of the following health information only to:

Name of Entity: _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Covering the period of health care from (date) _____ to (date) _____. The purpose of this request or disclosure is _____.

☐	Breast & Cervical	☐	Financial Records	☐	Maternity/Prenatal
☐	Child Health	☐	Genetics	☐	Medical History *
☐	Complete Medical Record	☐	HIV/AIDS	☐	Medication Records
☐	Consultation Reports*	☐	Hospitalization	☐	Progress Notes *
☐	Diabetes	☐	Hypertension	☐	STD (other than HIV/AIDS)
☐	Family Planning	☐	Laboratory Test	☐	Other:
*Identify Program by Name:		For CMP Use:			

This authorization shall be limited to health information pertaining to the following: (check if applicable)
I understand that I may revoke this authorization at any time except to the extent that action has been taken thereon. I further understand that this authorization will expire in 90 days from the date below.

_____ Date: _____
Patient or Representative's Signature (if patients representative signs please identify authority to act for the patient)

_____ Date: _____
Signature of Health Department Representative

Confidentiality Note: This information has been disclosed to you from records whose confidentiality is protected. Statutes/Regulations prohibit you from making further disclosures other than treatment, payment or health care operations, without the specific written authorization of the person to whom it pertains, or as otherwise permitted by such regulations. Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by Federal Laws. Federal Regulations (42 CFR, Part II) prohibits making any further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by such regulations.

MSDH use only
PHI **request** sent - Date: _____ Initials: _____
PHI **released** from Health Department - Date: _____ Initials: _____